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Debating the comprehensive basis of western healthcare systems in the light of neo-liberalism

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Abstract

The wide range of literature on the subject of healthcare reforms makes it difficult to clearly identify some of their main implications. We therefore try to further the debate with this introductory paper which aims to highlight the argument of the individual-oriented nature of health policies nowadays. It specifically refers to the consequences of the current neo-liberal context for public intervention in countries where health policies were originally collective-oriented with a view to comprehensive coverage.

Following this analytical discussion, we scrutinize some empirical data gathered from the 2011 OECD Health Data that are particularly relevant to this issue. Although different patterns are found in western countries, there is evidence that users cannot rely solely on tax and insurance when accessing health services but increasingly have to use their own sources of finance. This is in total contradiction with the ideological basis underpinning public policies that called on states to intervene for a more equal society. Given that the best financial solution is not necessarily in the users' best interest, it is important to analyse the extent to which efficiency is replacing equity.

Keywords: healthcare, health reform, rationalisation, co-payment, social inequalities in health, individual-oriented health

Introduction

Has anything changed since the time when states played a crucial role in providing comprehensive healthcare? If so, are such transformations meaningful enough to change the way health is financed, delivered and, more importantly, viewed as a social right?

This paper addresses these questions with the aim of fostering the discussion on some of the implications of health reforms in western societies. It is an introductory contribution to the recent scientific attention devoted to the regulatory shape of healthcare systems which follows the reflection for many years on the internal functioning of hospital organisations. More specifically, the intention is to discuss the extent to which recent policies rationalising public expenditure affect the principle on which health –understood in a broader sense – was based in most western countries: towards a collective-oriented principle.

Back to the time when public health issues were first raised, healthcare and other related dimensions such as birth, ageing and dying moved from the invisible and private sphere of families to become everyone's concern (Foucault, 1979; Herzlich and Pierret, 1987; Lupton, 1995). That was the advent of social policies and of 'public good', understood as synonymous with collective interests. It is in everyone's interest because at some point in people's live they will benefit from public intervention whether through healthcare, education, social security, or others. (Offe, 1984; Esping-Andersen 1985). After all, and underlining Goodin, Rein and Moran's argument (2006: 9): 'the point of politics is to constrain markets'.

Nevertheless, the dominant political trend in most western economies, where right-wing parties are currently in control, may have consequences on the image and role that states are expected to play in governing societies. This is generally described as a neo-liberal context which has political, economic and, more importantly, ideological consequences (Mirowski and Plehwe, 2009). In fact, regardless of the uncertainty about the implications of such changes on public intervention or the structural strength of neo-liberalism in the future, academics need to debate the reasons so that the majority of voting citizens endorse this political trend. It should be noted that we do not propose a normative argument. On the contrary, the main goal with this paper is to highlight the processes that

contribute to a better understanding of health reforms and some analytical dimensions apart from the ideological debate.

We first start by focusing on the differences between the past and present contexts of health policies, and then go on to discuss some OECD data on the global variation of out-of-pocket payments and the global variation of the health expenditure.

From the advent of public policies to the current neo-liberal context

The answers to our initial questions are difficult to find due to the specific characteristics of each country.

We therefore start by making some comments that help guide our argument. First, the information respects analytical processes that do not refer concrete cases. No reference is given to time and place are provided as these aspects are embedded in each country's historical, political and economic configuration. However, this discussion is particularly relevant to countries where health became a collective issue at some point in their history, either along the lines of Bismarck or Beveridge. On one hand, the Bismarckian system implies less state influence, social security is funded by salaried employees, and non-profit hospitals and individual practitioners are responsible for the care delivery; on the other hand, the Beveridgean system is based on general taxation and the state assumes the main responsibility for financing and delivering comprehensive care to the population free of charge basis (van der Zee and Kroneman, 2007).

The table below summarises some of the main dimensions that give us a better understanding of the advent of public and neo-liberal policies.

Table 1 – From a collective to an individual-oriented health

Dimensions	When?	Public policies	Neo-liberal policies
Demographic trend		Short life expectancy (high bird and mortality rates)	Long life expectancy (low mortality and bird rates)
Economics	Goods production	Growing: many resources for the consumption needs and money available	Consolidated to declining: fewer resources for the consumption needs and money available
	private accumulation of wealth	Developing	Consolidated
	wealth flow	National	Global
	Key-actor in decision making	State	Market (profit owners) and international institutions
Nature of diseases		Epidemiologic/contagious	Chronic and degenerative
Medical activity	Scientific knowledge	Developing	Consolidated
	Nature of the procedures	Human-based interaction	Technology-based interaction
	R&D funding	Public: growing Private: growing	Public: decreasing Private: stabilised to growing
	Health financing	Complementing public-private relationship	Competing public-private relationship
	Health delivery	Public: growing Private (profit and non-profit): Growing	Public: decreasing Private (profit and non-profit): stabilised to growing
	Health care coverage	towards comprehensiveness (public and/or private)	towards a limited comprehensiveness (either public and private)
Meaning of health		**Towards a collective-oriented concern**	**Towards an individual-oriented concern**

a) The public health era

Generally speaking, the advent of health policies coincided with a period of great economic, scientific and philosophical expansion in the mercantilist Europe of the 18th century (Herzlich and Pierret, 1987; Lupton, 1995) alongside the medicalisation of society (Conrad, 1992). The trend towards the 'normalisation', 'normativisation' and 'moralisation' of human bodies (Foucault, 1979; Armstrong, 1983) increasingly brought the collective issue of health and illness within the scope of medical knowledge. Progressively, the body became an important tool for industrial production and the accumulation of wealth within a

flourishing economic system based on capital flows that was confined at first to geographic borders but gradually moved to a global market.

Scientific knowledge in bacteriology and antibiotics allowed medicine to consolidate its place in society as the only and growing knowledge capable of dealing with the biologic nature of illness (Fee and Porter, 1992). In fact, the positive impact of medical procedures on adverse demographic trends for the accumulation of wealth was one of the most important milestones that reinforced medicine's position.

States increasingly become more responsible for ensuring standardised medical practice and training, with more hospitals and schools being built in response to a collective demand for comprehensive healthcare – whether this was delivered and financed by the public sector or privately. This point warrants special note. Some well-known cases, such as Germany, Benelux, France or Switzerland did not adhere to the format of a National Health Service but they provided their population with collective-oriented protection schemes. Therefore, it is not whether these services were provided by the public or the for-profit sector that is at stake, but rather the format on which they were based. In these cases, there is no less access to healthcare than in the UK, Finland or even Portugal even though the health service was financed and delivered privately through social security systems. Indeed, it was the first Chancellor of the German Empire, Otto von Bismarck, who set up Europe's first comprehensive healthcare system with the aim of achieving more effective control over health and illness. His option was to develop the strong public regulation of medical self-governance.

In short, several points of view provide insights into the extent to which the era of public policies gave preference to a comprehensive understanding of welfare , here understood not only as a way of minimising the effects and uncertainties caused by the private accumulation of wealth, but more importantly one that respects the principle that equal needs require equal access. The underlying concept, thereafter enshrined in a legal principle, is that everyone should belong to some kind of welfare structure (provided by the state or others) because they will benefit from comprehensive and inclusive public policies at some point in their lives.

b) The current neo-liberal context

Turning to the advent of neo-liberal policies, the mechanisms pushing health towards an individual-oriented system in liberalised welfare regimes are clearly visible (Esping-Andersen, 1990). This does not mean there no welfare rights, but that policies have become much more targeted and less universal (Sefton, 2006).

According to Rhodes (1994), economy, efficiency and effectiveness [3 Es] have had a huge impact in most countries; they have affected the states' expected role and function and, consequently, the way distributive policies of welfare are defined. Economies are no longer growing as they did in the past due to the global complexity of the economic activity. Moreover, states now have to deal with global competitiveness, the problem of regulating capital flows in the global market and the increasing importance of international investors (Hay, 2006). In sum, these combined processes have led to a transfer of power in decision making from the national sphere to the globalised market of capital flows (e.g. in the pharmaceutical sector). In addition, a highly technological medical practice is a huge challenge for the financing of healthcare procedures, whether the insurance scheme is public or private. Not only have the costs of medical practice risen due to the number and nature of medical procedures performed but the nature of diseases have also changed with more cases of chronic and degenerative diseases requiring specialised, long term care; moreover, states are exposed to the global interests of the R&D industry that have growingly shifted to the global market. .

The current problem is to find the right balance between welfare efficiency and equity. According to Mitchell, Harding and Gruen (1994) these two principles are compatible and possible to follow. Nevertheless, one should question whether Rhodes' 3 Es (1994) are negatively impacting the collective nature of health policies. There have been always winners and losers in the distribution of welfare policies, so the important issue is to what extent the pursuit for efficiency is successfully constricting the provision of comprehensive healthcare. We believe that the nature of the public-private relationship is one of the key differences between public policies in the past and nowadays. The biggest transformation in terms of R&D funding, health financing and delivery is their competitive nature, with the public and for-profit private sectors competing for the same resources and patients. This is particularly important in NHS countries, where some privatisation

processes have been described though not yet fully understood. These governments have followed a strategy to rationalise public expenditure by reducing their responsibilities in the finance and/or delivery of healthcare. This process is combined with the strengthening of the for-profit private market where there is effectively no state regulation of prices. The consequences are complex and not fully explored in this paper. For now, my focus goes specifically to discussing the risks to the collective definition of health when the conditions for accessing healthcare are individualised. There is a clear contradiction between more private players competing against the public sector and the dominant neo-liberal : on one hand, the public is committed to the population's general interests (democratic-oriented), however vague the principle, and accept that public intervention has never included everyone in its distributive policies, while on the other, the for-profit sector is guided by the accumulation of profit as the only possible mechanism to reproduce investment (economic-oriented) (Béland, et al, 2008; Correia, 2009).

Towards an individual-oriented healthcare: empirical evidence on co-payment

The analysis of co-payment, also known as cost sharing, helps shed light on the transition towards an individual-oriented health . Co-payment refers to the amount of money that people pay out of their own pockets when consuming healthcare; it is in addition to any pre-existing means of health financing, be they public (taxes and public insurance schemes) or private (private insurance schemes, professional or others, and non-profit organisations). It encompasses a wide range of situations described worldwide in which the consumption of drugs has received particular attention (e.g. Huttin, 1994).

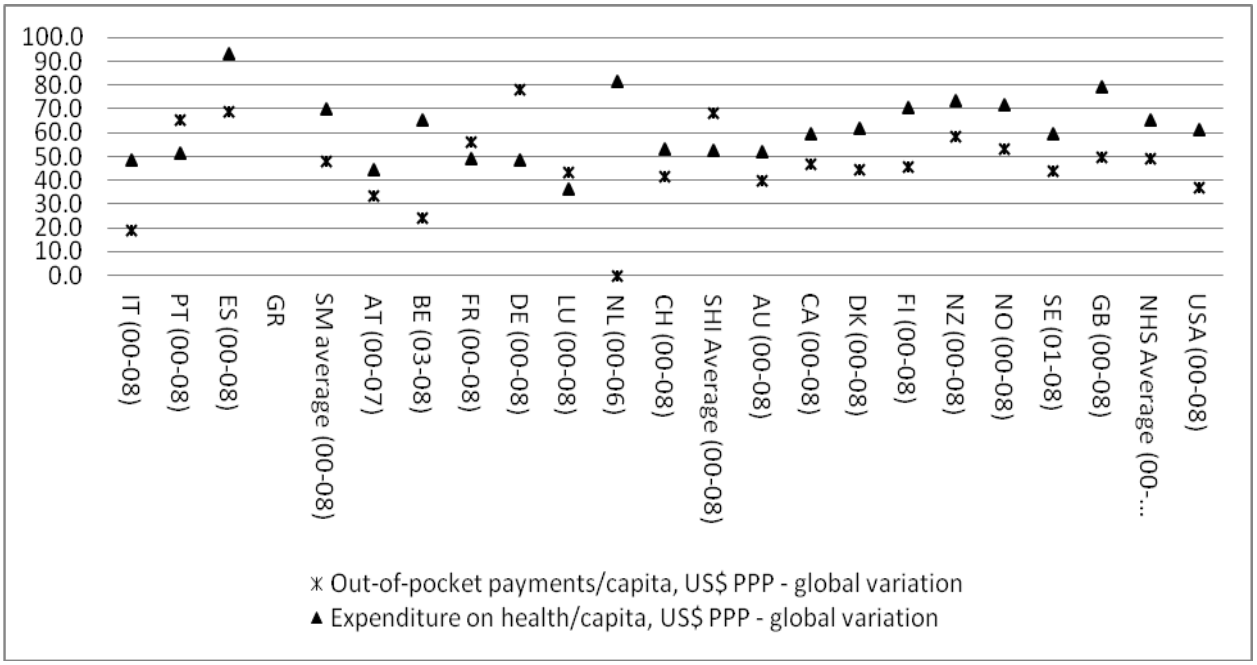
For the purposes of clarity, we start by making a brief distinction between the concepts of privatisation and rationalisation as co-payments is the result of the latter. As mentioned before by privatisation we mean the process of transferring the ownership and governance of public services to the for-profit private sector in a market context. This is clearly just one possible configuration of the public-private relationship, and it highlights the potential negative consequences for the functioning of the public sector, and the way people access and pay for their health (for other possible implications of public-private relationship see OECD, 2004; Collyer and White, 2011, where there is clear evidence on complementary, supplementary or substitute dynamics between public and private sectors).

On the other hand, the rationalisation of public expenditure is a process generally aimed at minimising waste. It represents the concern for making choices between the means and the ends, which increases processes typically associated to the concept of bureaucracy such as the pursuit for quantitative standards (Gerth and Mills, 1958). Therefore, managerialism is expected to open the public sector to the rules and principles of the rationalism of the private sector (Gruening, 2001), often seen as the only way of providing more predictable and efficient management (Hoggett, 1996).

In line with these principles, shifting the financial burden from the provider to patients is viewed as an incentive to deter unnecessary or marginal utilisation (see Gabel, LoSasso; Rice, 2002; Austvoll-Dahlgren, et al, 2009). However, Rice and Matsuoka (2004) draw attention to unexpected consequences of this rational economic behaviour, especially with regard access to healthcare. We note that the key-point is to determine whether efficiency is negatively shaping equity in the health sector. This analysis serves as an introduction to the theme. As yet, we can go no further than to make conjectures as to the meaning of people who access healthcare having to double or even triple their expenses on top of taxes or *earmarked premiums*.

Figure 1 presents data on two indicators: global variation of out-of-pocket payments and global variation of expenditure on health. The countries selected are usually referred to in some of the most recent debates on health policies (e.g. Saltman, 2003; Colombo and Tapay, 2004; Schmid et al, 2010); they which were grouped according to their formal health care model: National Health Service – NHS – (Australia, Canada, Denmark, Finland, New Zealand, Norway, Sweden, and UK), Social Health Insurance – SHI – (Austria, Belgium, France, Germany, Luxemburg, Netherlands, and Switzerland) and Private Health Insurance – PHI – (USA). Following evidence from the previous discussion, we opt to put Greece, Italy, Spain and Portugal in a separate group ('southern model' – SM –, see Ferrera, 1996). These are often described as a cohesive group that share a hybrid regulatory shape; here, the formal NHS came later than in the northern European countries and is less sustainable and it is complemented by a private sector usually associated to the Bismarck countries.

Figure 1 – Global variation of co-payments and expenditure on health in the OECD



Source: OECD 2011 Health Data

The first conclusion from this figure is that the overall costs of healthcare in all countries under analysis rose between 2000 and 2008; this was particularly evident in Spain, the Netherlands and Great Britain. An analysis of performance of the four healthcare systems reveals that the Southern Model recorded the highest average growth, followed by the National Health Service (NHS), the USA (namely Private Health Insurance) and finally Social Health Insurance (SHI). In the existing literature, van der Zee and Kroneman (2007) conclude that costs in SHI countries are higher than in countries with the NHS where cost containment is also better. This means that despite the efficiency recorded, the policies implemented over the last decade in NHS countries have raised the price everyone is paying for healthcare, including the state. *The literature has not yet provided clear answers and a comparative research agenda is therefore called for.* Nevertheless, there are strong signs of a change in the understanding of health as a social right; this is precisely the argument of this paper As discussed previously, states are under considerable pressure not to reduce social rights, which is particularly difficult in the current liberal context. This also raises the discussion on the impact of managing the public sector close to rules based on rules hitherto limited to the private sector. Despite the generally accepted idea that public and

private sectors share similar dynamics, there is an insurmountable difference, namely , the mechanisms that guarantee their sustainability. Whereas the state maximises profit by keeping people away from health care, the underlying logic of the private system is precisely the opposite, i.e. it strives to create the necessary conditions to increase health consumption (is there any other way of defining a sustainable market?) (see once more Béland, et at, 2008 or Correia, 2009).

Figure 1 also sheds light on the internal dynamics in these three groups of countries.[1] While the dynamics of the two indicators under analysis are consistent in NHS, there are striking divisions in both SM and SHI that should be stressed; however, further comment on particular national features goes beyond the scope of this macro level. By definition, SHI allows each country to adopt decentralised mechanisms to provide and finance healthcare and these may vary from one country to the other, . In this case, states are not required to deliver universal healthcare as it is provided by compulsory insurance together with healthcare regulated by the state (for a detailed description see Kuhlmann, et al, 2011 and Kuhlmann, et al, 2012). On the other hand, southern countries formally have defined a NHS which envisages comprehensive and universal healthcare. To find different patterns in these countries means that specific measures taken at the national level to tackle the costs with the health sector are responsible for divergent results: The global expenditure on health in Spain rose more than 90% in 8 years; in Portugal co-payments increased more than the overall expenditure on health (about 68%); Italy remained close to the NHS average and had one of the smallest upward trends in the evolution of co-payment .[2]

The third conclusion from Figure 1 is that the rise in co-payments is higher than the overall expenditure on health per capita. In other words, the amount health care providers expect users to pay out of their own pockets is higher than the overall rise in the cost of health. Although the s data does not reveal how this translates into the real price of health care, it clearly demonstrates situations that it is the users and not the providers that are bearing the brunt of more expensive health.

Portugal is the only non-SHI country where this dynamic is found. Other cases are France, Germany and Luxemburg. Although an in-depth comparative analysis is required to

[1] Apart from this analysis is the PHI model only composed by a single country.
[2] There was no available data for Greece.

determine As seen previously, it is just not possible nor was the intention to look at the reasons for these dynamics, it can be said that health provision nowadays has become more individual-oriented. Both states and insurers expect users to contribute more to the cost of their health care at a time when this has become more expensive than ever before. Politicians and scholars should address the issue of social inequalities raised by this trend. Nevertheless, the data demonstrate that this situation is not commonly felt among OECD countries. For example, health care users in Belgium, Great Britain, Finland, Spain and Italy are not required to pay anything in addition to pre-existing taxes and/or health insurances, despite the rising costs.

Conclusion

Healthcare systems are changing but they have followed divergent patterns. The main contradiction is found when we think of the advent of the public policies as the state's intervention to ensure a more equal society in that the best financial solution is not necessarily in the users' best interestsAlthough many believe that the state uses public polices to ensure a more equal society, it must be remembered that the best financial solution is not necessarily in the users' best interest.. In fact, the advent of public policies on health and other well-being issues, notably in the 20th century, cannot be detached from historical events that favoured a shared awareness of public interest and general needs. Remaining question is to know to which extent is current neo-liberal context responsible for an ideological change of the role states are expected to play in the near future.

The data presented in this paper strives to foster the debate among social scientists on health policies. The aim was not to be critical or normative, but once again, to highlight some of the ongoing changes that may lead to transformations in the perception of health as a social right.

The defence of individual-oriented health in terms of both healthcare provision and financing clearly indicates the trend towards the principles of economy, efficiency and effectiveness. On one hand, governments argue they are unable to maintain the same level of social rights. On the other, the principles adopted by for-profit private sector are not necessarily collective-oriented. In light of these principles, it is the users' individual responsibility to ensure the cost of healthcare is covered. The problem is that these were not

the principles underpinning the advent of public health services. If this kind of health system is to be adopted, further analysis is required. Nevertheless, it is not yet clear empirically how this trend will emerge in the future despite the fact that we have seen that it is analytically possible and should be taken into consideration when discussing healthcare systems . One thing is clear: a healthcare system that requires users to provide several forms of financing will lead to a different and less collective health.

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